

## PEER REVIEW HISTORY

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## ARTICLE DETAILS

<b>TITLE (PROVISIONAL)</b>	What are the needs and preferences of patients and family members discharged from the emergency department within 24 hours? A qualitative study towards a family-centred approach
<b>AUTHORS</b>	Østervang , Christina; Lassen, Annmarie; Jensen, Charlotte; Coyne, Elisabeth; Dieperink, Karin

## VERSION 1 – REVIEW

<b>REVIEWER</b>	Schull, Michael Sunnybrook and Womens Hospital, Emergency Department
<b>REVIEW RETURNED</b>	05-May-2021

<b>GENERAL COMMENTS</b>	<p>I appreciate the opportunity to review your paper on an important topic. These suggestions and questions are offered to help clarify and strengthen your study.</p> <p>1) Your objective is "to explore and understand the needs and preferences of patients and family members discharged from the ED within 24 hours of admission." That is very broad, can you provide more precision? Do you mean in relation to the care they received in the ED? Do you mean their needs and preferences at the time they were interviewed, and if so, about what?</p> <p>2) I think the methods section would benefit from some added detail. For example, I am unclear on what "the study was built around user involvement" means. Similarly, you describe doing "field observations" but it is unclear what this means.</p> <p>3) Your target was 20 patients, but does this mean 20 interviews with either a patient and/or a family member? Can you clarify how the decision was made to interview a patient alone, a patient with a family member, or a family member alone?</p> <p>4) By interviewing patients and/or family member, are you not assuming that the needs and preferences of patients and family members are the same when they might in fact differ? Did your method allow you to assess this?</p> <p>5) Can you clarify the purpose of field observation? You say, "the authors were able to directly obtain knowledge about how participants experienced the ED, as opposed to what we think is the case" using field observation, but what is meant by "what we think is the case"? Who is "we", and what is being referred to? How were these field observations correlated or compared to interviews?</p>
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	<p>6) You present quotes and provide some context which is helpful. The quotes are quite compelling. But what data was collected from field observations? Is that presented somewhere else? How is that data integrated with your interview data?</p> <p>7) In the conclusion you characterise the quotes that you provided as relating to things like "vulnerability", but I am not clear on how you came to the conclusion that that is an over-arching conclusion compared to other points raised?</p> <p>8) Your objective is to determine the "needs and preferences of patients". It would be helpful if you identified the differences, for example is vulnerability reflective of a need or a preference or both? Similarly for other findings, and whether needs and preferences differ between patients and family.</p> <p>9) Can your conclusions regarding the importance of including family members be sustained given the very small number of family members you interviewed? Can you convincingly conclude that patients (especially those interviewed alone) would agree with this?</p>
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<b>REVIEWER</b>	Redley, Bernice Deakin University, Geelong, Centre for Nursing Research – Deakin University and Monash Health Partnership
<b>REVIEW RETURNED</b>	14-Jun-2021

<b>GENERAL COMMENTS</b>	<p>Thank you for the invitation to review this manuscript that reports a qualitative study of the needs and preferences of patients and their family who experienced a short stay in the emergency department. Overall the manuscript was easy to read, had a logical flow, and was well presented. I have provided a number of suggestions below intended to assist the authors to improve the manuscript.</p> <p>Limitations. The first point in this section should be revised to make the strength (i.e. the element of rigour) or limitation (i.e. potential source of bias) explicit.</p> <p>In the second paragraph of the introduction, the link between the ED and out-of-hospital care is not clear ( i.e. are these services intended to provide a substitution model for ongoing ED or inpatient care or to support early discharge). Similarly, later in the same paragraph, the definition of a short ED stay ( i.e. clarify why 4-hours is described then 24 hours subsequently used for the study) and the rationale for investigating family needs and preferences would benefit from further development.</p> <p>I suggest the authors avoid anthropomorphisms in the statement of the research aim.</p> <p>Please explain what is meant by family and patients being involved in the early phase of the study: i.e. who was involved, how did this occur. The authors may choose to remove this section as it does not seem to add to the paper, rather it raises questions that are not addressed and does not appear to be related to the study reported.</p> <p>The design of the study is vague (e.g. abstract), unclear and inconsistent as references are made to multiple designs</p>
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	<p>throughout the manuscript (e.g. references are made to phenomenological enquiry, ethnography, qualitative study with inductive thematic analysis applied, and systematic text condensation for analysis). The authors should provide a clear statement of the design used, the rationale for selection, and ensure the application is consistent and aligned with the methods and the analyses that are used.</p> <p>The description of the selection of participants, and the recruitment process should include details about how participants were identified, informed and consented to be involved in the study. Explain how purposive maximum variation sampling (as stated in the abstract) was applied (i.e. the criteria used, how these were decided). Describe how it was decided who to approach, and when, how many were approached and subsequently participated. Explain when the patient and family were recruited, how was it known that they were a short stay.</p> <p>Move details of data collection from the participants and recruitment section to the data collection section.</p> <p>Detail of the COVID-19 restrictions may be better placed in a section about the context of the study and should also be addressed in the limitations.</p> <p>Explain who was asked for consent to contact the family/ patient after discharge. Provide the rationale for excluding patients with cognitive impairment if a family member was present and low and high triage categories, particularly in the context of using maximum variation sampling as stated in the abstract.</p> <p>State the sample size that was included and the rationale for including more than the desired 20.</p> <p>On page 8, lines 43-46 should be revised to improve clarity.</p> <p>The table reporting participant characteristics would be better placed in the results section of the paper.</p> <p>The description of the data collection is not provided with sufficient detail or clarity for replication. For example, how was it determined when the field observations occurred? When the field observations were undertaken in relation to the ED stay (i.e. the start, the end) and the duration of observations.? What was included in the observation guide or the focus of the observations (i.e. the patient, their family, both)? When were the interviews conducted? How many were conducted with each patient or family group (i.e. during the observations as well as afterwards as a follow-up? How were the observations linked to the interviews while protecting confidentiality? How were the observations analysed in relation to the interviews?</p> <p>The authors should state the number of coders used to analyse the data, if only one this should be noted, along with the potential source of bias and strategies to mitigate, in the limitations. As the focus of interest was patient and family member perspectives, it should be made clear how these were differentiated from each other in the methods and the analyses. It is not clear why interviewing together for 'both parties to gain a</p>
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	<p>broader understanding of each other's perspectives'. Explain how this was not a potential source of bias if the phenomenon of interest was the perspectives of each group.</p> <p>Please provide either the interview questions or examples of the types of questions asked. It would also be useful to understand how the researchers managed family groups in an interview if their perspectives differed.</p> <p>The description of NVIVO is not consistent with the use of this software as a data analysis tool: explain what is meant by 'was applied'.</p> <p>Explain how table 3 relates to the findings reported.</p> <p>It would be useful to have a description of the characteristics of the participants such as age, gender, how long they were in the ED, types of patient conditions, the number of previous ED [presentations etc. so the broader relevance and transferability of findings can be judged.</p> <p>Some of the illustrative quotes do not appear to support the preceding text e.g. concerns about the progress of the illness, new medications etc is followed by a quote about asking their mother-in-law to stay up. The link here is not clear. the authors should carefully select quotes that clearly support the text.</p> <p>The authors should also be careful about reporting findings not supported by the data: for example, how do they know the nurses and physicians were thorough in communicating discharge information (p. 12, lines 22-25).</p> <p>As reported, the findings do not differentiate between patients and family needs, any similarities or differences, hence it is not clear that the study objectives have been met.</p> <p>In the discussion, it would be useful for the authors to group similar ideas together and use multiple citations for a similar concept of idea, rather than describing each paper separately.</p> <p>The authors should also avoid contradictions, for example, they state no studies explored time after discharge and then later in the same paragraph report a qualitative study that appeared to do this. (p. 17)</p> <p>In the discussion, the authors should also be careful when comparing findings from studies with very different designs (e.g. qualitative and RCT, p. 17) as it is self-evident there will be differences as these are inherent in the study types. They should consider such implications.</p> <p>It is not clear what the authors mean by the main finding " the need to identify the vulnerability of the patients and family". this needs further explanation- such as who should be identifying this, and how and when can they do this, or was this universal: before suggesting interventions.</p> <p>When describing the limitations the authors should state the implications of the limitation (e.g. potential source of bias ) and any strategies used to mitigate these. The authors may like to consider</p>
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	limitations related to not returning transcripts to participants or checking the interpretation with participants such as member checking.
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### VERSION 1 – AUTHOR RESPONSE

Reviewer 1 comments	Author comments	Changes in the manuscript
1) Your objective is "to explore and understand the needs and preferences of patients and family members discharged from the ED within 24 hours of admission." That is very broad, can you provide more precision? Do you mean in relation to the care they received in the ED? Do you mean their needs and preferences at the time they were interviewed, and if so, about what?	Thank you very much for pointing this out. We agree more precision is needed to understand that ED care was the focus in this study. We have specified the objective.	On page 3 & 5.  "This study aims to explore and understand the needs and preferences of emergency care from the perspective of patients and family members discharged from the ED within 24 hours of admission. "
2) I think the methods section would benefit from some added detail. For example, I am unclear on what "the study was built around user involvement" means. Similarly, you describe doing "field observations" but it is unclear what this means.	Thank you.  We have deleted "user-involvement" in this section, as it refers to the overall design of the three-phased PhD study and we agree it might cause confusion instead of clarity.  We have specified details on field observations in the section 'Data collection'.	Page 3.  Sentence deleted.        Page 8.  "Field observations helped the authors to understand how the interactions and activities in the ED informed experiences, needs and preferences [25]. Furthermore, it provided first-hand knowledge of consistency between what actually happened and what was said in the interviews[25]. Inspired by Spradley's nine dimensions, [27] an

		<p>observational guide was designed and pilot-tested in two cases. The observational guide contained e.g. human interactions, time and events in the ED. CØ was present at the EDs for three to six hours per day, during both morning and evening shifts, and made observations in medical and surgical areas. CØ followed the patients during their stay joining them in the hospital room, examinations ect.. Duration of the observations varied in respect for the patient's wishes from 30 minutes to 4 hours. Field notes were written each day containing observations and quotes."</p>
<p>3) Your target was 20 patients, but does this mean 20 interviews with either a patient and/or a family member?</p> <p>Can you clarify how the decision was made to interview a patient alone, a patient with a family member, or a family member alone?</p>	<p>Thank you for your comment.</p> <p>We targeted at 20 patients, and did not set up a specific target number of family members to include.</p> <p>The patients decided how they wanted to participate in the interview; alone or joined. Their choice was often made in relation to logistical limitations, not wanting to disturb their family members or not specified.</p> <p>We have clarified this aspect in the manuscript.</p>	<p>Page 6.</p> <p>"No specific target sample was set for family members."</p> <p>Page 8.</p> <p>"The authors wanted to give the participants the power to decide which interview form they preferred. Therefore, participants were presented of the possibilities of a joined interview or individual interview and the authors followed their request."</p>
<p>4) By interviewing patients and/or family member, are you not assuming that the needs and preferences of patients and family members are the same when they might in fact differ? Did your method allow you to assess this?</p>	<p>Thank you for this question. We designed the interview guide with questions which allowed the interviewer to openly explore the family members perspective as well as patients perspective in such both individual and joined</p>	<p>On page 8-9.</p> <p>Running changes in the section 'Interviews'</p>

	<p>needs were discussed. E.g. the interviewer asked the family member: (The patients name ) tells she needs more clarity in the discharge information, what did you experience? Did you have the same need?</p> <p>We have added examples from the interview guide as well as the above mentioned.</p>	
<p>5) Can you clarify the purpose of field observation? You say, "the authors were able to directly obtain knowledge about how participants experienced the ED, as opposed to what we think is the case" using field observation, but what is meant by "what we think is the case"? Who is "we", and what is being referred to? How were these field observations correlated or compared to interviews?</p>	<p>We have clarified the sentence, and added more details in the analysis section.</p>	<p>As noted above - on page 8</p> <p>"Field observations helped the authors to understand how the interactions and activities in the ED informed experiences, needs and preferences [21]. Furthermore, it provided first-hand knowledge of consistency between what actually happened and what was told in the interviews."</p> <p>On page 9</p> <p>"The data from field observations and the interviews were analysed separately and then combined across the participant interaction to understand the deeper aspects of health professional interchanges with participants and the participants recollection of the interaction and information. After step four all data were synthesized. CØ was in charge of the coding process. During the coding process the author group met to discuss</p>

		the codes as strategy to mitigate potential bias.”
6) You present quotes and provide some context which is helpful. The quotes are quite compelling. But what data was collected from field observations? Is that presented somewhere else? How is that data integrated with your interview data?	<p>Thank you. Your comment directed attentions towards the very small proportion of field notes presented in the manuscript and the unclarity this could cause.</p> <p>We agree that more field notes could be added in the analysis to visualize how the authors worked with the data. We have added supportive field notes to the analysis.</p> <p>Moreover, we have added information on how the data were synthesized in the analysis section.</p>	<p>Page 11</p> <p>Field notes are added running in the result section.</p> <p>“The physician is having a long conversation with him. Pleasant atmosphere. They both smile. They have eye contact. They agree on the plan of discharge (fieldnote, August 2020)</p> <p>I only remember that I was not allowed to drive, but actually I do not know for how long? (Patient talking about his experience reflected in the fieldnote, male in this 60s)”</p> <p>On page 9</p> <p>“The data from field observations and the interviews were analysed separately and then combined across the participant interaction to understand the deeper aspects of health professional interchanges with participants and the participants recollection of the interaction and information. After step four all data were synthesized. CØ was in charge of the coding process. During the coding process the author group met to discuss the codes as strategy to mitigate potential bias. “</p>



<p>7) In the conclusion you characterise the quotes that you provided as relating to things like "vulnerability", but I am not clear on how you came to the conclusion that is an over-arching conclusion compared to other points raised?</p>	<p>Thank you for this comment.</p> <p>We do not think vulnerability is supposed to be an over-arching conclusion. Therefore, we have rephrased the section not emphasizing a particular need.</p>	<p>Page 20 and abstract</p> <p>"This study demonstrates that there is a gap between the needs and preferences of patients and family members and what the emergency department delivers. The findings highlight patient and family members needs an increased focus on them being in a vulnerable state of mind having needs and preferences for person-centred information with genuine involvement of family members. "</p>
<p>8) Your objective is to determine the "needs and preferences of patients". It would be helpful if you identified the differences, for example is vulnerability reflective of a need or a preference or both? Similarly for other findings, and whether needs and preferences differ between patients and family.</p>	<p>Thank you for these suggestions. We have tried to be more specific in clarifying needs and preferences throughout the result section .</p>	<p>Page 12</p> <p>Details added running in the result section.</p>
<p>9) Can your conclusions regarding the importance of including family members be sustained given the very small number of family members you interviewed? Can you convincingly conclude that patients (especially those interviewed alone) would agree with this?</p>	<p>Thank you for pointing this out.</p> <p>It is correct that only a few family members are represented, which we think is a limitation. But to mitigate this all patients, interviewed alone or joined, were asked into perspectives of family involvement.</p> <p>We have added an example of an interview question for better transparency.</p>	<p>On page 8.</p> <p>An example of an interview question is: "What significance does family have in your lives?"</p>

Reviewer 2 comments	Author comments	Changes in the manuscript
<p>Limitations.</p> <p>The first point in this section should be revised to make the strength (i.e. the element of rigour) or limitation (i.e. potential source of bias) explicit.</p>	<p>Thank you for pointing this out. After your very useful comments we decided to rewrite the limitation section as we found more details were needed. We hope you will find it more accurate.</p>	<p>Page 19</p> <p>Running changes in 'limitations'</p>
<p>In the second paragraph of the introduction, the link between the ED and out-of-hospital care is not clear ( i.e. are these services intended to provide a substitution model for ongoing ED or inpatient care or to support early discharge).</p> <p>Similarly, later in the same paragraph, the definition of a short ED stay ( i.e. clarify why 4-hours is described then 24 hours subsequently used for the study) and the rationale for investigating family needs and preferences would benefit from further development.</p>	<p>Thank you for directing attention towards the unclarity. We have specified the sentence.</p> <p>The 4 hour rule does not define a short stay in the ED, but is a rule for the HCP to develop a preliminary plan. We found no clear international definition of short stays, and chose 24 hours for this present study, as it in a Danish context is found to be between 0-48 hours. Often patients stay in the ED longer than 4 hours to get the last result of examinations or blood samples before discharge.</p> <p>We have added the information and specified details.</p>	<p>On page 4</p> <p>“telehealth and outpatient clinics to support ongoing treatment initiated in the ED as well to support early discharge.”</p> <p>“Across 21 Danish EDs, the same structure exists to promote clinical assessment and treatment plans of patients within four hours, a short stay in a Danish ED typically range from &lt;4 - 48 hours [2]”.</p>
<p>I suggest the authors avoid anthropomorphisms in the statement of the research aim.</p>	<p>That is correct the sentence was incomplete. We have specified it.</p>	<p>Page 5.</p> <p>“Emergency department”.</p>
<p>Please explain what is meant by family and patients being involved in the early phase of the study: i.e. who was involved, how did this occur. The authors may choose to remove this section as it does not seem to add to the paper, rather it raises questions that are not</p>	<p>Thank you, we have included this information. Prior, we had thought it mandatory to include according to BMJ author guidelines.</p> <p>We have now specified , and hope it has provided with more clarity.</p>	<p>Page 5</p> <p>“The local patient and family member council have read the study protocol and gave suggestions for improvements.”</p>

addressed and does not appear to be related to the study reported.		
The design of the study is vague (e.g. abstract), unclear and inconsistent as references are made to multiple designs throughout the manuscript (e.g. references are made to phenomenological enquiry, ethnography, qualitative study with inductive thematic analysis applied, and systematic text condensation for analysis). The authors should provide a clear statement of the design used, the rationale for selection, and ensure the application is consistent and aligned with the methods and the analyses that are used.	<p>Thank you for this comment. The overall research design is Participatory design which takes a phenomenological and hermeneutical stance. The research design uses traditionally ethnography combined with interviews to identify 'user needs' of the research field. (In this case the main users of the field are patients and family members).</p> <p>We have tried to create a better consistency and clarity and specified and added details regarding to participatory design.</p>	<p>Page 5:</p> <p>"Participatory design (PD) is this study's research methodology [19]. PD has a phenomenological and hermeneutical stance using qualitative methods towards understand lived experiences and needs of individuals[19, 20]. As methods, field observations and interviews with patients and family members were chosen."</p>
<p>The description of the selection of participants, and the recruitment process should include details about how participants were identified, informed and consented to be involved in the study. Explain how purposive maximum variation sampling (as stated in the abstract) was applied (i.e. the criteria used, how these were decided).</p> <p>Describe how it was decided who to approach, and when, how many were approached and subsequently participated. Explain when the patient and family were recruited, how was it known that they were a short stay.</p>	<p>Thank you for pointing this out.</p> <p>We have added details of how the participants were selected by adding table 1 creating an overview of the target group. Also, we have added and clarified details on the recruitment process.</p>	<p>Page 6 and 7</p> <p>Running changes in the section "participants" and "recruitment"</p> <p>Overview of target group population is added as table 1.</p>
Move details of data collection from the participants and recruitment section to the data collection section.	We agree this is placed better in the data collection section.	<p>Page 7/8</p> <p>Section moved.</p>

Detail of the COVID-19 restrictions may be better placed in a section about the context of the study and should also be addressed in the limitations.	Thank you. We have placed the details in the section “setting” and elaborated in the section “limitations”.	<p>Page 6 and 19.</p> <p>The details have been placed in ‘setting’, and is also addressed in the limitations.</p> <p>Page 19</p> <p>“At the time of the study, COVID 19 restrictions allowed presence from one family member. We enrolled family members present in the hospital, which could have caused the small sample size and could also have caused selection bias.”</p>
Explain who was asked for consent to contact the family/ patient after discharge. Provide the rationale for excluding patients with cognitive impairment if a family member was present and low and high triage categories, particularly in the context of using maximum variation sampling as stated in the abstract.	<p>Thank you for this comment. We have added the details regarding consent for interviews in the section ‘recruitment’</p> <p>Moreover, details on triage categories are added.</p> <p>Regarding cognitive impairment the author group discussed this very much, so thank for the comment. We chose to exclude patients with cognitive impairment for several reasons but the main reason was that we think this group of patients have particular complex needs and would require a separate study to get an in depth understanding. Further, the patients with cognitive impairment are most likely not short stay patients. The authors discussed this as a potential future research. The information is added in limitations.</p>	<p>On page 6</p> <p>“Patient triaged at the highest and lowest triage level as per the Danish Emergency Process Triage were excluded [23]. The highest triage level is received care in trauma room and not expected to be discharged within 24 hours. The lowest triage level is received care for minor cut or concern by either a nurse or a physician with no examinations.”</p> <p>Page 19 ‘limitations’</p> <p>“Furthermore, we did not include patients with cognitive impairment due to the complexity of the patient category; this is suggested for future research.”</p>
State the sample size that was included and the rationale for including more than the desired 20.	<p>The information’s are added and specified.</p> <p>The number of included patients is to be found in the result section.</p>	<p>Page 6</p> <p>” A target minimum sample was 20 patient, but data collection continued until thematic saturation [24] as well</p>

		as completing a pre-defined target group (table 1). No specific target sample was set for family members. Features were defined by the research group to ensure diversity represented.”
On page 8, lines 43-46 should be revised to improve clarity.	The sentence has been rephrased to provide clarity.	<p>Page 7</p> <p>“A phenomenological-hermeneutical approach allowed the researcher to recognise her perceptions as an experienced emergency nurse within hermeneutic interpretation (Green &amp; Thorogood, 2014). To enable recognition of the researchers preconceived ideas CØ wrote down her preunderstanding of why patients lack information being discharged and might have many concerns. (26). This reflection provided an initial focus for research questions (26).”</p>
The table reporting participant characteristics would be better placed in the results section of the paper.	We agree and have moved the tables to the result section.	<p>Page 10 and 11.</p> <p>Tables are moved to the result section.</p>
The description of the data collection is not provided with sufficient detail or clarity for replication. For example, how was it determined when the field observations occurred? When the field observations were undertaken in relation to the ED stay (i.e. the start, the end) and the duration of observations.? What was included in the observation guide or the focus of the observations (i.e. the patient, their family, both)?	<p>We have made major revisions to provide the insufficient details, we have specified and added the information in the section ‘recruitment’ and ‘field observations’.</p> <p>Interviews were conducted only one time with each participant two-seven days after their ED visit. The observations were used to get specific experiences or activities elaborated during the interview.</p>	<p>Page 7 and 8</p> <p>Running changes in the section ‘recruitment’ and ‘field observations’.</p> <p>Page 8.</p>

<p>When were the interviews conducted? How many were conducted with each patient or family group (i.e. during the observations as well as afterwards as a follow-up? How were the observations linked to the interviews while protecting confidentiality? How were the observations analysed in relation to the interviews?</p>	<p>E.g. "At the end of the stay you talked to a nurse, can you tell me about that experience?"</p> <p>The details are provided and specified.</p>	<p>Running changes in the section 'interview'</p> <p>Page 9.</p> <p>" The data from field observations and the interviews were analysed separately and then combined across the participant interaction to understand the deeper aspects of health professional interchanges with participants and the participants recollection of the interaction and information. After step four all data were synthesized."</p>
<p>The authors should state the number of coders used to analyse the data, if only one this should be noted, along with the potential source of bias and strategies to mitigate, in the limitations.</p> <p>As the focus of interest was patient and family member perspectives, it should be made clear how these were differentiated from each other in the methods and the analyses. It is not clear why interviewing together for 'both parties to gain a broader understanding of each other's perspectives'. Explain how this was not a potential source of bias if the phenomenon of interest</p>	<p>Thank you, we agree that the information was needed.</p> <p>Only one person coded the data, but several times during the coding process the author group met to discuss the codes to mitigate potential bias in the coding process.</p> <p>Thank you for this question. We designed the interview guide with questions which allowed the interviewer to openly explore the family members perspective as well as the patients in such both individual and joined needs were discussed. E.g. the interviewer asked the family member: (The patients name ) tells she needs more clarity in the discharge information, what did you experience? What did you need?</p> <p>Our aim was not to report on similarities and differences.</p>	<p>Page 9</p> <p>"CØ was in charge of the coding process. During the coding process the author group met to discuss the codes as strategy to mitigate potential bias."</p> <p>Page 8-9</p> <p>"The interview guide was pilot tested in two cases. An example of an interview question is: "What significance does family have in your life's?" Data from the observations were used directly in the interview where it seemed relevant to elaborate on e.g. "At the end of the stay you talked to a nurse, can you tell me about that experience?" Interviews were conducted</p>

was the perspectives of each group.	We have added examples from the interview guide as well as specified above mentioned.	one time two to seven days after discharge.”
Please provide either the interview questions or examples of the types of questions asked. It would also be useful to understand how the researchers managed family groups in an interview if their perspectives differed.	Information is added and specified.	Page 9 As above.
The description of NVIVO is not consistent with the use of this software as a data analysis tool: explain what is meant by 'was applied'.	The sentence is rephrased for clarity.	Page 9 “NVivo12 was used to store, code and systematise data”
Explain how table 3 relates to the findings reported.	Thank you. The intention was to show an excerpt of the analysis process, but we agree this could be confusing , therefore, we have removed the table.	Table 3 removed.
It would be useful to have a description of the characteristics of the participants such as age, gender, how long they were in the ED, types of patient conditions, the number of previous ED [presentations etc. so the broader relevance and transferability of findings can be judged.	We have placed the accessible data on patient characteristics in table 2.	Page 10 and 11. Table 2 and 3.
Some of the illustrative quotes do not appear to support the preceding text e.g. concerns about the progress of the illness, new medications etc is followed by a quote about asking their mother-in-law to stay up. The link here is not clear. the authors should carefully select quotes that clearly support the text.	We agree the link could be better and we have selected another quote.	Page 12 “She talks in the phone. She says that no one asked if she was able to handle things at home. “But I need home care, how do we do this?” she asked her family during the phone conversation(fieldnote, October 2020).”

The authors should also be careful about reporting findings not supported by the data: for example, how do they know the nurses and physicians were thorough in communicating discharge information (p. 12, lines 22-25).	We agree the data needed support. Therefore, we have added a fieldnote to provide clarity.	<p>Page 13</p> <p>“The physician is having a long conversation with him. Pleasant atmosphere. They both smile. They have eye contact. They agree on the plan of discharge (fieldnote, August 2020).</p> <p>I only remember that I was not allowed to drive, but actually I do not know for how long? (Quote from the same patient as above fieldnote, male in this 60s).”</p>
As reported, the findings do not differentiate between patients and family needs, any similarities or differences, hence it is not clear that the study objectives have been met.	<p>Thank you for your comment. It is correct that the study did not report on similarities and differences in needs of patients and family members. We aimed to get the participants to elaborate on their individual experienced needs either joint or individual. Afterwards we gathered the needs analytical, but did not aim to report what were found in common or diverse.</p> <p>But, you really provided with an interesting point towards future research, thank you.</p>	<p>Page 19</p> <p>“For future research similarities and differences in the needs of patients and family members could create a broader understanding of emergency care.”</p>
In the discussion, it would be useful for the authors to group similar ideas together and use multiple citations for a similar concept of idea, rather than describing each paper separately.	Thank you, we have tried to group ideas where it seemed possible.	<p>Page 17</p> <p>“A need for clear communication has also been found in previous research [33-35]. A protocol for discharge communication in the ED, could support and train HCPs to possess person-centred communication skills [33]. Moreover, implementing a “protected and undisturbed</p>



		time” for HCPs when entering a discharge conversation [34].”
The authors should also avoid contradictions, for example, they state no studies explored time after discharge and then later in the same paragraph report a qualitative study that appeared to do this. (p. 17)	We agree this appeared as a contradiction which was not intended, therefore, we have deleted the sentence	Page 18  Deleted “None of the studies explored the time after discharge.”
In the discussion, the authors should also be careful when comparing findings from studies with very different designs (e.g. qualitative and RCT, p. 17) as it is self-evident there will be differences as these are inherent in the study types. They should consider such implications.	Thank so much for pointing this important aspect out. We agree that this only should be done with great consideration.  We chose to include the results of the RCT from these arguments 1) it is from the same organizational health care system as our study 2) we only refer to secondary endpoints which relates to patient experience of discharge (as our findings)	None
It is not clear what the authors mean by the main finding " the need to identify the vulnerability of the patients and family". this needs further explanation- such as who should be identifying this, and how and when can they do this, or was this universal: before suggesting interventions.	As reviewer 1 also commented, the sentence needs further explanation to be included in the conclusion.  We do not think vulnerability is supposed to be an over-arching conclusion. Therefore, we have rephrased the section not emphasizing a particular need.  The second phase of this three phased study is a design and development phase of an intervention to accommodate the identified needs.  Your questions: “who should be identifying this?, and how and when can they do this?, or was this universal?” will hopefully be	Page 20  “This study demonstrates that there is a gap between the needs of patients and family members and what the emergency department delivers. The findings highlight patient and family members need an increased focus on them being in a vulnerable state of mind having needs for person-centred information with genuine involvement of family members. “

	answered from second phase and reported on later.	
When describing the limitations the authors should state the implications of the limitation (e.g. potential source of bias ) and any strategies used to mitigate these. The authors may like to consider limitations related to not returning transcripts to participants or checking the interpretation with participants such as member checking.	<p>Once again thank you for your reflective comments.</p> <p>At the end of each interview, the interviewer summarized her perception of what was discussed during the interview and participants were offered to read the transcript. Two participants asked for the transcripts to be returned, this was done with no further comments.</p> <p>We have added this information.</p>	<p>Page 9 Interview section</p> <p>“At the end of the interview, the interviewer made at summarize to ensure correct interpretation as well as the participants were asked if they would like to read the transcript. Two participants accepted with no further comments.”</p> <p>Page 19 Limitations:</p> <p>“An interview summarize was made along with offering participants to read the transcripts.”</p>

## VERSION 2 – REVIEW

<b>REVIEWER</b>	Redley, Bernice Deakin University, Geelong, Centre for Nursing Research – Deakin University and Monash Health Partnership
<b>REVIEW RETURNED</b>	09-Sep-2021

<b>GENERAL COMMENTS</b>	<p>Thank you for the invitation to review this manuscript that examined patient and family perspectives after discharge from the emergency department. Overall the manuscript reads very well, addressed an important topic, and makes a useful contribution to the literature on patient-centered care in EDs. I have provided a number of suggestions below that the authors may like to consider to improve the manuscript.</p> <p>The stated design should be consistent between the abstract and the methods section of the manuscript.</p> <p>There is a contradiction between the eligibility criteria and selection of patients for observation: the patient and family participant eligibility criteria suggest eligible participants could not be determined until discharge from the ED but the description of the method suggests participants were selected prior to this- these sections should be revised to ensure consistency.</p> <p>The participant eligibility section states that participants were discharged from the ED within 24 hours, however, the data collection section states that "No time restriction related to how</p>
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	<p>long the patients had stayed in the ED was set". These sections should be revised to be consistent.</p> <p>It would be useful to understand the types of changes to the protocol recommended by the local patient and family member council. The authors may like to consider the addition of a brief comment to this effect.</p> <p>I presume the COVID-19 restrictions related to was one family member to accompany each patient. This should be explicit, particularly as only 32 patients are admitted each day and some countries do not allow any visitors.</p> <p>In the results, the discussion of "Secure verbal and nonverbal language from HCPs was preferred..." requires some additional explanation. As a reader, I am not sure what the author means by this expression. This is partially addressed by the illustrative quote, but a clearer explanation would be useful.</p> <p>In the analysis section, the authors refer to 'step four': it is not clear what this refers to. An outline of the analysis with numbered steps would be useful to provide this context.</p> <p>The authors refer to limited cultural variability and socioeconomic characteristics as potential limitations, however, they do not report these in the participant characteristics. I suggest they either remove these comments from the limitations (and consider the sampling limitation instead) or add the details to the participant characteristics. Also, it is not clear why the visitation restrictions was considered a limitation as the sampling suggested that only family that accompany patients would be included.</p> <p>Overall the manuscript would benefit from additional editing to correct minor, but consistent grammatical and word choice errors, and paragraph structure.</p> <p>The captions for tables 2 and 3 could also be shortened.</p>
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## VERSION 2 – AUTHOR RESPONSE

Reviewer comments	Author response	Changes in the manuscript
The stated design should be consistent between the abstract and the methods section of the manuscript.	<p>Thank you.</p> <p>We aligned the abstract with the method section.</p>	<p>Page 3</p> <p>The study reports from the first phase in an overall Participatory design project. Systematic text condensation was used to identify key themes from field observations and interviews with patients and family members.</p>
There is a contradiction between the eligibility criteria and selection of patients for	Thank you.	Page 7

<p>observation: the patient and family participant eligibility criteria suggest eligible participants could not be determined until discharge from the ED but the description of the method suggests participants were selected prior to this- these sections should be revised to ensure consistency.</p> <p>The participant eligibility section states that participants were discharged from the ED within 24 hours, however, the data collection section states that "No time restriction related to how long the patients had stayed in the ED was set". These sections should be revised to be consistent.</p>	<p>We can see why this might have been unclear. Therefore, we clarified this information.</p>	<p>No time restriction related to how long the patients had stayed in the ED was set besides a criterion of discharge before 24 hours of admission.</p> <p>If the patient was not discharged as expected they were excluded from the study.</p>
<p>It would be useful to understand the types of changes to the protocol recommended by the local patient and family member council. The authors may like to consider the addition of a brief comment to this effect.</p>	<p>We agree and did add the information in the manuscript.</p>	<p>Page 5</p> <p>The local patient and family member council have read the study protocol and gave suggestions for improvements e.g., regarding sampling strategy and clarity of the patient population included in the study.</p>
<p>I presume the COVID-19 restrictions related to was one family member to accompany each patient. This should be explicit, particularly as only 32 patients are admitted each day and some countries do not allow any visitors.</p>	<p>We added the information, thank you for your attention towards this.</p>	<p>Page 6</p> <p>Visitor restrictions due to Covid-19 were in place in 2020, and only one family member per patient was allowed to accompany the patient in the ED.</p>
<p>In the results, the discussion of "Secure verbal and nonverbal</p>	<p>Thank you for pointing this out.</p>	<p>Page 14</p>

language from HCPs was preferred..." requires some additional explanation. As a reader, I am not sure what the author means by this expression. This is partially addressed by the illustrative quote, but a clearer explanation would be useful.	We provided more explanation for improved clarity.	Patients preferred communication from HCPs to be provided in a clear and concise way. Lack of confidence from the HCP negatively affected how patients were able to deal with their situations.
In the analysis section, the authors refer to 'step four': it is not clear what this refers to. An outline of the analysis with numbered steps would be useful to provide this context.	We added the missing information to provide clarity.	Page 9  The analysis was performed according to systematic text condensations four steps [29].  After this process all data were synthesized. CØ was in charge of the coding process.
The authors refer to limited cultural variability and socioeconomic characteristics as potential limitations, however, they do not report these in the participant characteristics. I suggest they either remove these comments from the limitations (and consider the sampling limitation instead) or add the details to the participant characteristics.  Also, it is not clear why the visitation restrictions was considered a limitation as the sampling suggested that only family that accompany patients would be included.	Thank you for your attention towards this section. We specified the section and provided more details.	Page 20  Telephone interviews prevented the interviewer from seeing facial expressions and body language, which reduced the ability to clarify answers if uncertainty [28]. Only family members at the hospital were recruited, leading to a small sample size and also potential selection bias. Having a strategy for recruiting family members not physically present in the hospital might have given a broader aspect into the family perspectives.
Overall the manuscript would benefit from additional editing to correct minor, but consistent grammatical and word choice errors, and paragraph structure.	The manuscript has been proofread.	Running

<p>The captions for tables 2 and 3 could also be shortened.</p>	<p>We shortened the captions in both tables.</p>	<p>Table 2: Characteristics of participating patients</p> <p>Table 3: Characteristics of participating family members</p>
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